



Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:

Wol+Med
2436 IH35E South, Ste. 336
Denton, TX 76205

MFDR Tracking #: M4-08-3506-01

DWC CI

Injured Emp

Date of I

Respondent Name and Box #:

TASB Risk Management Fund
Rep. Box #: 47

Employer I

Insurance Car

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "...The carrier failed to respond to our request for reconsideration. This claim has neither been paid nor been acknowledged as received. Sincere has been no acknowledgement, we cannot submit the EOB's for these claim(s). However, we are submitting proof of timely filing as well as proof of timely acceptance... It is the insurance carrier's obligation to furnish its agents with any documentation necessary for the resolution of a medical bill."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - \$452.23*
3. CMS 1500s
4. EOBs
5. Insert

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "...The documentation shows a practice and intent to bill for time not spent working with the claimant – for example, billing for time while the claimant is at lunch. Documentation of time spent on various activities is very unclear and must be taken on faith that hours billed were spent in therapeutic activity. Rule 133.210(C)(3) states the provider must "substantiate the care given". Without notations of time spent in each activity, there is no substantiation of care given..."

Principle Documentation:

1. Response to DWC 60
2. EOB

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
02/27/07, 03/02/07, 03/09/07, 03/16/07, 03/21/07, 03/23/07	CPT Code 97546-WH-CA (15 hrs x \$64.00 = \$960.00 - \$592.00 (carrier payment))	B13, W1, W4	1, 2, 4, 5	\$368.00
04/12/07	99456-WP-V5 (\$115.59 x 125% = \$144.48 + \$150.00 = \$294.48 - \$265.77 (carrier payment))	W1	1, 3, 5	\$ 28.71
Total Due:				\$396.71

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.202, titled *Medical Fee Guideline* effective for professional services rendered on or after August 1, 2003, set out the reimbursement guidelines.

* The Requestor submitted an up-dated table as additional reimbursement was received.

1. These services were denied by the Respondent with reason code "B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment. This bill is a duplicate of EOMB 1530742"; "W1 – Workers Compensation State Fee Schedule Adjustment"; "W4 – No additional reimbursement allowed after review of appeal/reconsideration"; and "B15 – Payment adjusted because this procedure/service is not paid separately."
2. The Respondent denied date of service 02/27/07 as "B-13 - previously paid..." and did not reimburse the Requestor according to 28 Texas Administrative Code Section 134.202(e)(5)(C)(ii). The Respondent used reason code "W1" but did not reimburse according to the fee guideline for dates of service 03/02/07 and 03/23/07. The Respondent used reason code "B15" for dates of service 03/09/07 through 03/21/07; per Rule 134.202(b) CPT Code 97646-WH-CA is not considered a global or component code. Therefore, additional reimbursement is recommended.
3. Per 28 Texas Administrative Code Section 134.202(e)(6)(C) and (D) the Respondent did not reimburse the Requestor correctly. Therefore, Reimbursement is recommended.
4. Per Division Rule at 28 Texas Administrative Code Section 133.307(d)(2)(B) the carrier's defense of "no substantiation of care given" was raised after the filing of a MFDR request.
5. Per review of Box 32 on CMS-1500, zip code 76205 is located in Denton County. The maximum reimbursement amount, under Rule 134.202(b), is determined by locality.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section. 413.031 and Section. 413.0311
28 Texas Administrative Code Section. 133.307, 134.1, 134.202
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to additional reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of \$396.71 plus applicable accrued interest per Division Rule 134.130, due within 30 days of receipt of this Order.

ORDER:

Authorized Signature

Medical Fee Dispute Resolution Officer

May 8, 2008

Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within 20 (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.